Schedule amount was $27.60. Therefore, Acordia should have only paid $22.08 (80% of $27.60). The overpayment for Monroe County's 80% portion on this one CPT code was $208.32. A claim should only be processed as a referral if it is not a network provider. Acordia's management produced computer reports to determine the extent of the overpayment.

For the period January 1, 1999 through August 18, 2003, five Dimension providers were overpaid a total of $83,997.72. Acordia is in the process of recouping the overpayments. Acordia has received payment from one Dimension provider in the amount of $7,058.19.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should monitor the collection process of the overpayment due the County.

County Administrator's Response:

1. **Management believes claims should always be processed as network provider and if no network shows up, the system should check for referral before decision to assess penalty. The referrals are generally lab tests and the quantity of them should not be prohibitive for checking. The processing of lab tests on a referral basis was implemented because management believed it was unfair to the participants to have them responsible for finding a network lab. Group Insurance Management is reviewing the Referral Analysis Report to prevent this from occurring again.**
2. **Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, we have had eight providers opt out of the network.**
3. **As identified above by the auditors, Acordia is already in the process of recouping the overpayments. Management will be sure that this continues. In the future, management will establish a periodic review of claims by the County's insurance consultant for the purpose of identifying and resolving problems.**

2. KPHA provider claims paid as referrals

Finding:

Numerous KPHA provider claims were paid as referrals, but the providers are actually participants in the KPHA Network. This was determined by review of the Referral Analysis Report. Providers paid as referrals were paid at the in network rate of 80% or 100%. A claim should only be processed as a referral if it is not a network provider. Acordia's management produced computer reports to determine the extent of the overpayment.

For the period January 1, 1999 through August 18, 2003, the KPHA providers were overpaid a total of $3,774.68.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should monitor the collection process of the overpayment due the County.

County Administrator's Response:

1. **Management believes claims should always be processed as network provider and if no network shows up, the system should check for referral before decision to assess penalty. The referrals are general lab tests and the quantity of them should not be prohibitive for checking. The processing of lab tests on a referral basis was implemented because management believed it was unfair to the participants to have them responsible for finding a network lab. Group Insurance Management is reviewing the Referral Analysis Report to prevent this from occurring again.**
2. **Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, eight providers have left the network.**
3. **This is a similar situation to the previous finding. Management will be sure that this continues. In the future, management will establish a periodic review of claims by the County's insurance consultant for the purpose of identifying and resolving problems.**
4.

3. KPHA dental providers added to Acordia's system incorrectly

Finding:

Five dental providers in KPHA were added to Acordia's system incorrectly or not properly updated. Acordia provided the auditors a report correctly calculating the discounts and an overpayment of $22,685.90 was made to the providers. Acordia corrected the discounts and notified the providers of the overpayments and $5,715.18 has been received.

Incorrect payments would have continued indefinitely since the set-up did not contain accurate information. Acordia should furnish KPHA a provider listing with tax identification numbers and discount percentages allowed to review and correct on a periodic basis.

Recommendation(s):

1. Group Insurance Management should monitor the collection process of the overpayment due the County.

2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.

County Administrator's Response:

1. **Group Insurance Management will continue the collection process.**
2. **Effective January 1, 2004, Monroe County has ceased being a self-insured provider of Dental services. Employees are paying for their own insurance through American General.**
3. **Group Insurance Management will utilize the services of the insurance consultant for the purpose of monitoring Acordia's listing of all KPHA Network Providers to be sure that it is accurate.**

B. Payment Method Employed for Surgical Procedures

Finding:

Group Insurance stated that payment for surgical procedures should be calculated according to Medicare's Multiple Surgery Guidelines and was under the assumption that Acordia was using this method. This assumption was based on a letter sent to Acordia from Group Insurance requesting Medicare guidelines be used for unbundling. See Exhibit A - Letter to Acordia, June 18, 2001.

Acordia states unbundling of charges and multiple surgeries guidelines are two different issues. See Exhibit B - E-mail from Acordia, August 26, 2003. Their system, Code Review, already bundles and unbundles procedure codes including surgeries. The multiple surgery guidelines are applied after the procedure codes have been bundled or unbundled. The following claim is an example of unbundling:

CPT Code 43750 and 43246 were combined into one code 43246. There was also another procedure code 36533 for $1,200. Acordia stated, our Nurses have indicated that this procedure was not performed through the same incision as the primary procedure, therefore, we did not reduce to 50% of the Medicode Fee. However, based on Medicare's Multiple Surgery, which differs from ours, this would have been reduced to 50% regardless and should have been limited to 50% of $1,200 or $600.

The auditors requested Acordia to reprice all surgery claims from October 1, 2001 through June 30, 2003 and Acordia informed the auditors this was unrealistic and not feasible. See Exhibit B - E-mail from Acordia, August 26, 2003. The auditors were unable to determine the extent of overpayment resulting from the miscommunication between Acordia, KPHA and Group Insurance Management.

Acordia is able to amend the plan with written instructions based on the e-mail of August 26, 2003 from Acordia. See Exhibit B -E-mail from Acordia, August 26, 2003. There has been no correspondence between the County and Acordia clarifying the guidelines to be implemented.

Recommendation(s):

1. Group Insurance Management should discuss the consequences of using Medicare's Multiple Surgery Guidelines with KPHA.

2. Group Insurance Management should also consider including an acknowledgment form to be signed by Acordia Management that states the change has been made and the date it was implemented.

County Administrator's Response:

1. Group Insurance Management has discussed both Multiple Surgery Guidelines and Unbundling with KPHA. We are satisfied with the procedure being used by Acordia on unbundling. After much discussion and research, we have agreed to the following Multiple Surgical Procedures that will be included in the next plan revision:

Surgery includes the medically necessary preoperative and post operative care, when performed by a Physician. If two (2) or more operations or procedures are performed on the same day, on the same patient, by the same Physician, benefits are described in the Schedule of Benefits and subject to the usual, customary, and reasonable charges (or network fee schedule) for the first procedure, and 50% of usual, customary, and reasonable charges (or network fee schedule) for any additional procedures performed.

2. Group Insurance Management will develop an acknowledgement form to be signed by Acordia stating the appropriate changes have been made and the date of the implementation.

C. Discounts Rescinded by Providers

Finding:

The auditors reviewed Single Provider Payment Listing reports for the network hospitals and requested a sample of claims that did not have the appropriate discount applied. The review identified Fisherman's Hospital rescinding discounts on claims that were not paid within 30 days by Acordia. Acordia informed the auditors if additional information is requested the 30 days begins after receipt of all documentation necessary to analyze the claim and process appropriately. Acordia paid the original billed charges less the provider discount and if the claim was paid past the 30 day period the hospital would request the discount be paid. See Exhibit C - Sample Letter from Fisherman's Hospital. The sample of 6 claims revealed a total of $33,716.48 paid to Fisherman's Hospital based on discounts rescinded.

The KPHA contract provides the following definition for provider compensation:

Participating Provider Compensation: All claims for covered services, whether payable by the Employer or a Covered Person will receive a discount off of provider billed charges as specified in Attachment A. This discount will be rescinded if an appropriately documented and

non-contested claim is not paid to the Participating Provider within thirty (30) days of being received by the claims administrator (Acordia National).

Group Insurance Management is working with KPHA to revise the contract language to define clean claims and disputed claims. See Exhibit D - Email from KPHA.

Recommendation(s):

1. Group Insurance Management should ensure that Acordia calculates prompt pay discounts according to the terms of the KPHA Proposal and Agreement.
2. Group Insurance Management should review Refund and Reversal reports provided by Acordia to monitor provider discounts that have been refunded.

County Administrator's Response:

1. **The language in the KPHA contract was confusing as to what constituted a 'non-contested claim'. In the new contract with KPHA, effective March 1, 2004, we have defined a "Clean Claim, "Notification of Claim Status" and "Disputed Claims". This should prevent the discrepancy caused with the handling of discounts such as those documented with Fisherman Hospital.**
2. **Group Insurance Management agrees with the recommendation to monitor the Refund and Reversal Report.**
3. **Group Insurance Management will officially inform KPHA that the practice identified for Fisherman's Hosptial is not within the scope of the Contract between the County and KPHA. KPHA will be asked to inform Fisherman's Hospital that practice must be discontinued.**

D. Overpayments Identified in May 2003 Health Benefit Program Audit

1. KPHA provider claims paid as referrals

Finding:

The initial audit dated May 27, 2003 identified physician claims for the KPHA network using an outdated Medicode Fee Schedule for the usual and customary comparison, which resulted in multiple claims being overpaid. The County requested the claims be reprocessed on August 5, 2003. See Exhibit E - Letter to Acordia, August 5, 2003. The total County adjustments calculated by Acordia resulted in an overpayment amount of $134,729.77. The providers have been notified and repayment of $36,666.22 has been received. As of February 12, 2004, the outstanding balance is $98,063.55.

Recommendation(s):

1. Group Insurance Management should monitor the collection process of the overpayment due the County.
2. Group Insurance Management needs to ensure procedures are in place to verify the Medicode Fee Schedule is updated annually.

County Administrator's Response:

1. **Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time (15 months) than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, eight providers have left the network. As of March 31, 2004 we have increased the repayment amount of $36,666.22 to $70,379.81.**
2. **We were the only client of Acordia that was using Medicode. It created a very cumbersome system for processing and updating. Effective March 1, 2004, our contract with KPHA has started using P.H.C.S. (formerly HIAA) Fee Schedule. All other Acordia Clients use P.H.C.S. This should make the processing and updating easier and more efficient. Acordia will update their system and it will be effective for all their providers. KPHA providers have agreed to this new system in their contract with KPHA.**
3. **Group Insurance Management will semi-annually confirm that the P.H.C.S. Fee Schedule is being utilized appropriately.**

2. Incorrect discounts for durable medical equipment

Finding:

The initial audit dated May 27, 2003 identified claims with incorrect discounts totalling $47,529.39. Included in the amount was $10,424.01 for durable medical equipment claims that did not have the standard KPHA discount of 15%. During the supplemental audit it was discovered the rates for medical equipment are negotiated by KPHA Case Management. The standard discount of 15% does not apply to durable medical equipment claims, but a case management fee is billed to the County. Subsequently, the auditors determined the overpayment identified as "incorrect discounts for durable medical equipment" should not have been included as an overpayment in the initial audit.

Group Insurance Management and KPHA agree the discount should not be applied to durable medical equipment. However, the contract does not indicate durable medical equipment is processed differently from other KPHA claims.

Recommendation(s):

1. Group Insurance Management should document and include all processing conditions in the contract.

County Administrator's Response:

1. **Group Insurance Management will document the processing for Durable Medical Equipment in the next plan document. As much as Group Insurance Management would like to be able to document all processing in our plan document, we continue**

to find unique medical situations that have to be handled administratively based on what serves the patient as well as what keeps the cost as low as possible for the plan.

2. 90th Percentile Medicode overpayment

Finding:

The initial audit dated May 27, 2003 identified claims being processed with the 1997 90th Percentile Medicode. Acordia ran preliminary reports identifying $52,877.70 as the overpayment due to the outdated Medicode. Included in the amount was $25,357.03 which was for one physician administrating prescription drugs. It had been determined by the County and KPHA that the service the physician provided would not be subject to the medicode comparison. However, the physician had discrepancies in his billing procedures and gave the appearance of an overpayment in the initial audit. For example, one claim was billed for 40 units at $30.09 with a total charge of $904.00 and a total of $858.80 was paid. The payment was correct even after being compared to the 90th Percentile of Medicode. The next claim billed 1 unit at $30.09 with a total charge of $904.00 and a total of $858.80 was paid, but the spreadsheet calculation gave the appearance of the claim being overpaid $830.21. The preliminary overpayment calculated by Acordia was prepared in a formula based spreadsheet and did not take into account examiner overrides. The physician will not be billed the calculated overpayment of $25,357.03 by Acordia.

Recommendation(s):

1. Group Insurance Management should review all documentation provided by Acordia to ensure calculations and procedures are accurate.

County Administrator's Response:

1. Group Insurance Management along with KPHA and Acordia are monitoring processing to maintain the accuracy of the system. Medicode will no longer be our basis; as of March 1, 2004, we will be using P.H.C.S. (formerly HIAA).

E. **Network Providers Billing with Multiple Tax Identification Numbers.**

Finding:

Numerous providers are billing with more than one federal tax identification number. The claims were paid as out of network claims (70% coinsurance percentage and no discount) because the tax identification number did not match the one provided to Acordia by KPHA or Dimension. According to Acordia Management, this is a common issue for all networks. Providers don't always notify the networks when their tax identification numbers change and it ultimately results in claims being paid out of network. A provider can only be matched to a specific network if they bill their claims with the tax identification number provided to Acordia by the network. KPHA plans to provide both social security numbers and tax identification numbers to Acordia to update their claim system for all KPHA providers.

The auditors also discovered many network providers have multiple suffixes added to their tax identification number. This can be a result of a change of address, data entry error or

multiple locations and the provider may not be updated to the appropriate network. In addition, providers may be Group-Based and also provide services on an individual basis, therefore creating new suffixes and the potential of inaccurate processing.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.
3. Group Insurance Management should check the referral report on a monthly basis.

County Administrator's Response:

1. Group Insurance Management is aware that some providers bill under more than one federal tax identification number. This is done for a variety of reasons including their affiliation with other providers and location for providing the service. Some physicians are affiliated with a network in one location and not while practicing in another. When the provider supplies different federal tax identification numbers for these reasons, they can actually not be part of a network. Participants who believe they used a network doctor and were penalized for using a non-network provider should contact Acordia or the Group Insurance Office for assistance. Networks change on a frequent basis and it is the responsibility of the participant to verify network status before seeking treatment.

2. Group Insurance Management will establish guidelines to insure Acordia's listing of network providers is accurate and will utilize the services of the County's insurance consultant on a periodic basis to check the system.

F. Group Insurance Management Should Perform Regular Audits of Acordia Claims and Reports

Finding:

Group Insurance Management has been provided the ability to access Acordia's Host On Demand online claim system to allow audit and inquiries of claims. Numerous monthly reports from Acordia were provided to the auditors. The auditors reviewed the reports and found they had substantial benefits in identifying potential claim miscalculations. The following reports can provide Group Insurance Management information to monitor claims processed by Acordia:

1. Referral Report By Authorizing Provider - Monthly analysis of the report can quickly discover network providers paid as referrals and claims can be adjusted to properly reflect provider discounts.

2. Refund and Reversal Analysis - Monthly analysis of the report may help identify discounts rescinded and refunded to the provider. Timely review could provide the County the ability to document and correct discounts rescinded.

3. Single Payment Provider Listings - Monthly review may identify billed charges paid with an incorrect discount and can also provide claims to be selected for audit and inquiries.

4. Monroe County Employer Liaison Committee Agenda's - KPHA informs Group Insurance Management of provider additions and deletions. The changes need to be verified with Acordia to determine updates were completed accurately.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.

County Administrator's Response:

1. The above findings basically reflect a finding found throughout the audit. Management will be sure to develop ongoing monitoring and auditing ability so that these issues can be appropriately controlled.

2. Group Insurance Management is working with the consultant to establish a suitable method of audits and inquiries.

3. Group Insurance Management is concerned about proper listing of providers in the appropriate networks. However, the participant is the best source for insuring the proper accounting for network providers. The penalty for using an out-of-network provider is greater than many of our discounts. When an employee seeks medical treatment they should confirm that they are using a network provider. When precertifications are done, KPHA informs the participant when they have selected an out-of-network provider and will offer in-network alternatives to the participant. Group Insurance Management will continue to work on the accuracy of the network providers with Acordia.

G. **Group Insurance Management Should Provide Employee Education Regarding Health Care Claims**

Finding:

Monroe County has established an employee benefit plan for the purpose of providing medical, prescription, dental, vision, utilization review and Cobra benefits for its employees. Increasing health care cost has forced the County to implement changes that will financially impact the employees, dependents and retirees with the intent of decreasing the cost of health care for the County. As of January 1, 2004, the benefit plan was modified and resulted in an increased cost of dependent coverage, increased coinsurance payments, increased prescription copayments and provided the employee the option of paying a premium for elective dental and vision coverage.

Employee participation is an integral part of controlling health care cost. With proper information and education employees will have the ability to assist in reducing the overall cost of benefits.

The direct impact of increasing health care cost and decreasing employee benefits has provided employees an increasing awareness in monitoring their own claims. For example, an employee brought to the attention of the auditors they had received a check from Acordia for services that had not been rendered. The provider was requesting preauthorization, but submitted the request on a claim form and a check was issued to the employee. The check was subsequently returned. In another instance, the employee had surgery and scrutinized the billing upon receipt. The employee discovered a charge of an additional hour of surgery time that was not performed. The employee has pursued the issue and the billing is being adjusted.

Recommendation(s):

1. Group Insurance Management should establish a regular program to educate employees on health care benefits and provide the information necessary to scrutinize claims to protect the employee and the County from overpayments.

County Administrator's Response:

1. **Group Insurance Training is done at all New Employee Orientation with BOCC employees. All items that could cause discussion of the Group Health Insurance Program at a BOCC meeting are noticed to all active and retired participants in the insurance program. Changes to the Plan as adopted by the BOCC are noticed to all active and retired participants. In January 2002, Workers' Comp and Group began a county-wide program of training on those two programs. They were done in Plantation Key, Marathon, & Key West in January, February, March, April, June, and September, 2002 and January 2003. These training sessions were conducted with the various constitutional officers. Our Resource Link (newsletter for Board employees) notified employees that changes were to be voted on at the September 17' 2003 meeting of the BOCC and advising them that if they had not received the memo (that went to all employees and retirees) of the proposed changes, to contact the Group Insurance Office for a copy. Open enrollment was held in November outlining all changes to the program. American General did presentations on November 20. 2003 in Key Largo and Marathon and on November 21, 2003 in Key West on the Dental and Vision Programs. Group Insurance Management works diligently to keep all employees informed of the program requirements. Group Insurance will establish a new set of orientation sessions for employees throughout the Keys.**